A REPORT ON THE CONTAMINATED PLASMA DISCOVERED IN ENGLAND

On November 14, a cable addressed to Dr. Scudder was received from Dr. Drury of the Medical Research Council of Great Britain. It read:

> "Sterility tests upon random samples of saline plasma unsatisfactory."

In response to this message, a cable was sent in the name of Dr. Stetten to Dr. Drury, reading as follows:

> "Cable immediately hospital and numbers on cartons of unsatisfactory Plasma."

On November 15, a cablegram addressed to Dr. Stetten was received, signed by Dr. A. N. Drury, as follows:

> "8 flagons tested, following four contaminated Presbyterian 157 and 198 Baxter Laboratory College Point 62NTE01961 Mt. Sinai Pool 8."

This information was transmitted to the members of the Plasma Committee and to the directors of the Plasma Banks in the Hospitals from which the contaminated pools came.

A complete report concerning the contaminated Plasma from Presbyterian Hospital was sent to Mr. Bush by Dr. Scudder on November 16. Each of the two bottles tested had come from pools which had been twice tested aerobically and anaerobically and found negative for growth. It is of interest however that on the day that these two bottles were dispensed there were contaminations in three of the seven pools. This period was definitely the worst period in the operating experience of Presbyterian Hospital.

Pool No. 8 from Mt. Sinai Hospital was released by them on August 30, with a negative culture. It contained four bottles. This pool was reported as negative from the central laboratory at one week.

With this information in hand a cablegram was sent in the name of Dr. Stetten to Dr. Drury as follows:

11/19/40

> "Presbyterian Hospital contaminated pools in carton No. 17 Bottle 159 cartons 22, 32, 33, 34 and bottle 202 in carton 31. Throw out all Mt. Sinai pool 8. Cannot check 62NTE01961 without hospital name. All taken in August. Technique much improved now."

An attempt was made to check the source of Baxter No. 62NTE01961. Information from the Baxter factory indicated that it may have gone to one of five hospitals: Long Island, Memorial, New York, Post Graduate or Presbyterian. Since the Long Island College Hospital used these serial numbers for their own records and the bottle in question was not among them, this Plasma could not therefore have come from Long Island College. Memorial Hospital had not shipped any plasma at this date. New York Hospital at this time was marking their bottles with a distinctive letter for each pool and we feel that had it come from there this would have been made known to us in the cablegram.

The bottle must have come therefore from Post Graduate or Presbyterian and since Presbyterian Hospital on the day in question was known to have had a bad day it is felt that this bottle also was among the pools included in the list cabled to Dr. Drury. Therefore, if all of these are retested in England we feel that the entire contaminated lot will have been gotten rid of.

SUMMARY: The contaminated flasks were all prepared and shipped in August before the technique had been thoroughly worked out; before establishment of the central laboratory; before each pool was tested separately and at the time of the greatest difficulty. It is regrettable that any Plasma should have been shipped which later proved to be contaminated, but with the present system of checks and rechecks it is less likely that this will happen again. This accident should not invalidate the work as a whole, since it is well known that the British authorities are cognizant of the difficulties inherent in such a program.

A letter confirming the cablegrams was sent to Dr. Drury and the experiences and set-up of the Association were outlined as well as the care taken to insure against future contaminations. Definite word was also sought as to the need of our continued cooperation.

BLOOD PLASMA DIVISION
Charles R. Drew
Medical Superviser